ELSEVIER Clinical Skills

Anxiety - CE

ALERT

Patients with severe anxiety may experience panic, depersonalization or derealization, or become irrational.

OVERVIEW

Anxiety is different than fear. The two conditions share some similarities but have many differences. Fear is a natural emotional reaction to an impending threat. It has a direct cause and promotes safety. Anxiety is the expectation of an imagined or potential threat. It tends to be vague and unfocused. Fear is commonly combined with an acute arousal of the autonomic system needed for fight or flight and thoughts and behaviors associated with immediate danger and escape. Anxiety can affect emotions, thought processes, bodily sensations, and behaviors. With anxiety, vigilance, preparation for future threats, caution, and avoidant behaviors are more common.[1]

Anxiety is a physiologic response that can result from genetic vulnerabilities and psychosocial stressors. It can cause feelings of dread, apprehension, and worry in response to a perceived fear or stressor. Experiencing anxiety can affect how a patient functions on a daily basis and responds to care.

A patient's memories, experiences, and social situations play intricate roles in the experience of stress and the development of anxiety. The patient may experience vague stress stemming from past pain and suffering or fear.[13] Because these experiences are unique to each person, understanding the patient's stress and anxiety may be difficult.

Anxiety is characterized by:[3]

- Physical complaints (e.g., chest tightness, dizziness, nausea, headache); although these symptoms are typical of anxiety disorders, they may also indicate a significant medical issue, therefore a thorough physical assessment is required
- Cognitive symptoms (e.g., impaired judgment, confusion, inability to make decisions)
- Behavioral issues (e.g., avoidance, impulsiveness, isolation)
- Emotional symptoms (e.g., worry, irritability, sense of dread, a feeling of being overwhelmed, frustration)

An anxiety disorder often occurs concomitantly with physical, emotional, or mental illnesses or substance abuse. These other issues can hide or aggravate anxiety symptoms. Assessment for an anxiety disorder must be part of a comprehensive examination that includes a detailed history, physical assessment, review of symptoms, and assessments of associated functional impairments, current psychosocial issues, and other contributing factors.[4,16]

Patients may experience different levels of anxiety, which have different effects on daily functioning. Mild anxiety promotes productivity and problem solving because of increased mental focus. With moderate and severe anxiety, the ability to focus becomes increasingly difficult, and the anxiety symptoms become more intense and significantly impair the ability to function. During panic, the patient loses mental focus, and personality disorganization occurs, potentially to the point of experiencing depersonalization or derealization, or disruptions in consciousness or amnesia.[18]

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Anxiety disorder is the most prevalent psychiatric illness and interferes with a patient's ability to function.[17] According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*), anxiety disorders include:[1]

- Generalized anxiety
- Panic disorder
- Specific phobias (animal, blood-injection-injury, natural environment, situational, others)
- Social anxiety disorder (social phobia)
- Agoraphobia
- Other specified anxiety disorders
- Unspecified anxiety disorder
- Substance- or medication-induced anxiety disorder
- Anxiety disorder caused by another medical condition

Other conditions that have anxiety as a primary component or symptom include obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), acute stress disorder, adjustment disorders,[1] and major depression.[17] The most common anxiety disorders are generalized anxiety disorder, specific phobia, and social phobia. OCD occurs less frequently.[2] Women are more likely to experience a generalized anxiety disorder than men.[1]

- Generalized anxiety disorder involves excessive worrying.
- OCD consists of obsessive, persistent thoughts and compulsive behaviors.
- Panic disorder is characterized by panic attacks, which are sudden onsets of terror and impending doom.
- PTSD is a persistent reexperiencing of an event perceived as traumatic.
- Acute stress disorder is similar to PTSD, but the symptoms last for 3 days to 1 month after the traumatic event.[1]
- Phobias are persistent, irrational fears that lead to avoidance.
- Anxiety related to a medical condition can occur as a direct, physiologic result of various medical disorders, such as asthma, cardiac arrhythmias, hyperthyroidism, delirium, seizure disorder, or hypoglycemia.[1]
- Substance-induced anxiety is anxiety occurring after consuming a substance, after exposure to a toxin, or within 1 month of stopping the use of a substance.[1]

Anxiety disorders can be treated in a variety of settings, depending on the severity of symptoms and the interventions required for safe care. In most cases, anxiety disorders can be treated effectively with psychological interventions, which are recommended as the first-line treatment.[14] Practitioners should begin with low-intensity, minimally intrusive interventions and move to more high-intensity, invasive therapies, using a stepped approach. Common treatments include cognitive behavioral therapy (CBT), relaxation techniques, and pharmacologic treatment. In addition, support and self-help groups may be beneficial.[4]

Pharmacologic treatments are effective in treating more severe anxiety disorders and anxiety disorders that have not responded well to psychological interventions. Medication therapy is generally continued for at least 1 year[11] because of the high risk of relapse. Medication selection can vary depending on the specific anxiety disorder, severity and complexity of the disorder, age of the patient, comorbid conditions, likelihood of accidental overdose or deliberate self-harm, cost, patient preference, and prior therapies.[3]

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Medications commonly used for anxiety disorders include:

- Selective serotonin reuptake inhibitors (SSRIs) including sertraline, escitalopram, citalopram, and paroxetine
- Serotonin–norepinephrine reuptake inhibitors (SNRIs) including venlafaxine and duloxetine[3]
- Serotonin modulators including trazodone and mirtazapine
- Tricyclic antidepressants (TCAs) including amitriptyline, doxepin, and nortriptyline[3]
- Anxiolytics including buspirone and hydroxyzine[3]
- Beta blockers including propranolol and metoprolol[10]
- Anticonvulsants including gabapentin and pregabalin[10]
- Monoamine oxidase inhibitors (MAOIs) including selegiline and phenelzine[15]

Benzodiazepines and antipsychotics should not be used unless indicated. Combination medication treatment may be indicated for patients with more complex or refractory disorders.[3]

The efficacy and side effects of medications should be assessed frequently, especially when medication therapy begins or changes.

EDUCATION

- Provide developmentally and culturally appropriate education based on the desire for knowledge, readiness to learn, and overall neurologic and psychosocial state.
- Educate the patient and family about the signs and symptoms of anxiety.
- Educate the patient and family about how anxiety can interfere with health maintenance activities.
- Explain how medical illnesses can initiate or exacerbate anxiety symptoms.
- Identify accessible and realistic resources that treat anxiety and that help the patient cope.
- Educate the patient and family about emergency resources.
- Teach the patient to begin identifying how his or her anxiety manifests.
- Educate the patient and family about the different severity levels.
- Educate the patient about self-care techniques to manage anxiety, such as deep breathing, progressive muscle relaxation, guided imagery, and listening to music.
- Teach the patient the potential side effects of prescribed medications, the withdrawal symptoms if doses are missed or decreased or if therapy is stopped, the expected delay in the effect on symptoms, the anticipated course of treatment, and the importance of taking the medication as prescribed.
- Encourage questions and answer them as they arise.

ASSESSMENT

1. Perform hand hygiene before patient contact.
2. Introduce yourself to the patient.
3. Verify the correct patient using two identifiers.
4. Use an organization-approved standardized tool for suicide assessment.[9]
5. Assess the patient's level of anxiety by asking if he or she is experiencing any uncomfortable symptoms.
6. Assess the patient for physical symptoms of anxiety, such as tachycardia, diaphoresis, elevated blood pressure, increased respirations, and pain.
7. Assess the patient for somatic symptoms of anxiety, such as stomach distress, headaches, or muscle tension.

8. Assess the patient for nonverbal expressions of anxiety, such as grimacing, tense facial muscles, fidgeting, restlessness, or guardedness.
9. Use an organization-approved assessment scale (e.g., Hamilton Anxiety Scale) to assess anxiety.
10. Assess the patient's use of alcohol, nicotine, or illicit substances.
11. Assess the effect of the patient's medical illnesses on anxiety symptoms.
12. Assess the patient's level of comfort with health care team members entering his or her personal space.
13. Assess the patient's comfort level with having several health care team members in the room at one time.
14. Assess the patient's need for assistance in performing self-care activities.
15. Assess the need for a psychiatric practitioner consult and seek a consult as appropriate.
16. Assess the patient for problems with medications, including suicidal thoughts, side effects, and inadequate symptom management.

STRATEGIES

1. Perform hand hygiene.
2. Verify the correct patient using two identifiers.
3. Explain the strategies to the patient and ensure that he or she agrees to treatment.
4. Perform a physical and neurologic assessment.

    Rationale: A physical and neurologic assessment can help determine if the anxiety is primary or secondary to a separate psychiatric illness, medical illness, or substance use.[1,4]

5. Communicate with the patient to create a care plan.

a. Recognize when anxiety may be playing a role in the patient's symptomatology and behavior.

    Rationale: Patients may not feel comfortable experiencing or expressing anxiety symptoms or have knowledge of healthy coping strategies to manage them. Consequently, they may automatically use defense mechanisms or unhealthy coping strategies that protect them against feeling anxiety.[1]

    When patients cope with anxiety, they must use effective, not maladaptive, defense mechanisms. Maladaptive defense mechanisms may interfere with care and patient and family cooperation with treatment. Effective defense mechanisms help patients solve problems and follow instructions.

b. Review the patient's triggers to feelings of anxiety.
c. Encourage the patient to identify coping skills, medications, and social supports that have helped in the past. Consider inquiring about interventions that have not worked or have worsened the anxiety symptoms.

    Rationale: Engaging the patient in a discussion of what has worked or not worked provides valuable information for planning care.

d. Provide a safe environment based on unit practice and patient preference. Ask the patient what health care team members can do to increase the feeling of security and ease.

Rationale: A safe environment can help the patient feel accepted and promote verbalization of anxiety.

e. Incorporate recommendations from a behavioral health practitioner for specific interventions, if available.
f. Explain to the patient and family the strategies for treatment and confirm their understanding via verbal, written, or other means. Provide them with an opportunity to ask questions, express concerns, and give input on the treatment plan.

Rationale: Ensuring that the patient and family understand the strategies for treatment promotes acceptance of treatment. Involving the patient creates an exchange of information and shared decision-making, which improves outcomes.[8]

6. Confirm consent for implementing the care plan.

Rationale: The patient may determine that he or she does not want to accept a recommended strategy.

7. Provide the patient with clear, concise instructions on anxiety management.
8. Promote self-care activities.

Rationale: Maintaining optimal nutrition, hygiene, sleep, and relaxation activities can improve adaptive coping mechanisms, ultimately reducing anxiety severity.

9. Perform hand hygiene.
10. Document the strategies in the patient's record.

REASSESSMENT

1. Assess the patient for decreased anxiety.
2. Determine whether the patient recognizes his or her symptoms of anxiety.
3. Determine whether the patient verbalizes his or her symptoms of anxiety.
4. Determine whether the patient listens to and retains instructions and information.
5. Assess the patient's need for assistance with relaxation techniques and self-care activities.
6. Assess the patient's ability to identify triggers for anxiety and coping skills, medications, and forms of social support that decrease anxiety.
7. Assess the patient's response to changes in the environment.
8. Assess, treat, and reassess pain.

EXPECTED OUTCOMES

- Intensity of patient's anxiety level decreases.
- Health care team members, patient, and family recognize anxiety symptoms and triggers.

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- Patient is able to verbalize anxiety symptoms.
- Patient identifies and independently employs effective coping mechanisms and self-help techniques to reduce anxiety.
- Patient is able to ask for assistance and mobilize social support.
- Patient uses low levels of anxiety for positive motivation.

UNEXPECTED OUTCOMES

- Patient uses alcohol or illicit drugs to diminish anxiety.
- Patient's anxiety symptoms continue or worsen.
- Patient is unable to verbalize anxiety symptoms.
- Patient is unable to identify or employ effective coping mechanisms, relaxation techniques, or self-care activities.
- Patient does not ask for help or is unable to mobilize social support.
- Patient is unable to follow directions and retain educational information.
- Patient engages in self-harm activities or becomes suicidal.

DOCUMENTATION

- Observed symptoms of anxiety
- Reported symptoms of anxiety
- Psychoeducation for managing anxiety symptoms
- Strategies used to help reduce anxiety
- Patient understanding
- Family involvement
- Patient outcome
- Consultation requests and referrals
- Education
- Unexpected outcomes and related interventions

ADOLESCENT CONSIDERATIONS

- An appropriate communication style should be used for adolescent patients.
- Adolescent patients with anxiety disorders are more likely to demonstrate irritability and difficulty coping and functioning than others.[6] Agitation may develop more quickly and result in inappropriate and aberrant behaviors. Behaviors and interactions that may increase an adolescent's anxiety, such as confrontation, should be avoided.
- Research has shown that CBT is effective in adolescent patients and should be considered as a first-line treatment.[4]
- Careful consideration must be given before using SSRI medication in this population due to the potential for harm.[4]
- Anxiety disorders are common in adolescent patients and have a high risk of developing into lifelong mental health problems, especially if not treated.[4]

OLDER ADULT CONSIDERATIONS

- Generalized anxiety disorder is common in older adults and has significant consequences regarding quality of life, health, and functioning.[5]
- Certain medications used for anxiety (first-generation antihistamines, tertiary tetracycline antidepressants [TCAs], SSRIs, benzodiazepines) are more likely to cause adverse reactions or toxicity in older adults and should be avoided.[7]
- Treatment with medication and psychotherapy has been shown to improve symptoms of generalized anxiety disorder in older adults.[5]

- Practitioners may prescribe psychosocial treatments and CBT more commonly than high-risk medications because older adults typically prefer these methods, and they have been proven effective in this patient population.[5]

SPECIAL CONSIDERATIONS

- Women of childbearing age are at high risk of experiencing anxiety. An exacerbation of anxiety disorders during and after pregnancy can interfere with prenatal care, nutritional status, self-care, and the mother-infant relationship.[12]

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*In these skills, a “classic” reference is a widely cited, standard work of established excellence that significantly affects current practice and may also represent the foundational research for practice.

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- Level VI - Single descriptive or qualitative study
- Level VII - Authority opinion or expert committee reports

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- Sources of relaxing music

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